

SUMMARY REPORT

ICD-9-CM COORDINATION AND MAINTENANCE COMMITTEE

November 17, 2000

Introduction and Overview

Pat Brooks welcomed the participants to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coordination and Maintenance Committee meeting. All participants introduced themselves. An overview of the Committee was provided. It was explained that the Committee meetings serve as a public forum to discuss proposed revisions to the ICD-9-CM. The public is given a chance to offer comments and ask questions about the proposed revisions. No final decisions on code revisions take place at the meeting. After the meeting, a summary of the meeting is posted on the home pages of the Health Care Financing Administration (HCFA) and the National Center for Health Statistics (NCHS). The public is encouraged to send in written comments after the meeting, but prior to January 8, 2001. All written and oral comments will be considered prior to making a decision on final code revisions. The November 17, 2000 meeting was the last meeting at which proposed changes to ICD-9-CM for October 1, 2001 would be discussed.

The timeline was discussed. It was pointed out that the next meeting will be May 17-18, 2001. Topics discussed at this meeting will be for code changes effective October 1, 2002. Those requesting that topics be discussed at the May 17, 2001 meeting should submit them prior to March 17, 2001, as is indicated in the time line included in this report. An agenda for the procedure part of the meeting will be posted on HCFA's homepage one month before the meeting.

It was mentioned that the final notice on the Transaction Regulation naming national coding standards was published August 17, 2000. Those wishing to follow Health Insurance Portability and Accountability Act (HIPPA) activities should access the Administrative Simplification homepage. This can be accessed through links on both HCFA's and NCHS' home pages. It was stressed that no decision has been made on when or if ICD-10 will be implemented in the United States. These discussions could not begin while the Transaction Regulation was being cleared for publication. There is no tentative date for implementing ICD-10, since the topic has not yet been addressed through public hearings.

Implementation Issues on ICD-10 Procedure Coding System (PCS)

Pat Brooks informed the audience that an updated version of ICD-10-PCS was placed on HCFA's homepage in November 2000. This updated version contains all the suggested changes and revisions discovered through the extensive testing process. Although there were a number of changes to the index as well as clarifications to the tabular sections, there were no fundamental changes to the basic structure of the system. The repeated and extensive testing has shown the system to be quite sound.

The audience was reminded of the history of the project as follows:

- 1992 – award of contract for preliminary design
- 1993 – award of three year contract for entire system
- 1998 - first draft completed
- 1998-2000 - repeated testing of system
- November 2000 - final draft based on testing

The testing showed that the following objectives of the system were met:

- Completeness
- Expandability
- Hierarchically structured
- Standardized terminology
- Improved accuracy and efficiency of coding
- Reduced training time

The audience reviewed a report summarizing the major modifications to the 2000 draft. These included:

- Body parts added to some Root Operations
- Approaches added
- Other minor revisions including index entries

The audience was once again reminded of the process established by HIPAA for naming national standards. Any future coding system must be discussed in public meetings. Proposals for new systems must be described in a proposed rule. After a comment period, the final standards must be named in a final rule. Since ICD-10-PCS has been finalized and extensively tested, it is now time to evaluate it for implementation. The audience agreed that a decision must be made as to whether the current coding system, ICD-9-CM procedures, will continue to be used, or whether the nation should move to ICD-10-PCS as a replacement for ICD-9-CM, Volume 3, Procedures.

Public Testimony on ICD-10-PCS

To further this decision making process, a considerable part of the May 17, 2001 meeting will be devoted to discussing whether the industry should continue using the existing ICD-9-CM procedures, or whether ICD-10-PCS should be implemented as a new national standard. In order to facilitate discussion, major organizations, industry groups, manufacturers, publishers, and others will be offered the opportunity to make a 10 minute presentation on whether to move forward to a new procedure coding system or stay with the current system. Issues such as timing, training requirements, the need for public maintenance committees, and which organizations should participate in maintenance and guideline development should be addressed. Suggestions on who should lead the educational efforts will also be sought. The audience will also be provided an opportunity to discuss the issues presented and to ask questions.

Those organizations and groups who wish to make a presentation should contact Pat Brooks by March 17, 2001. It would be quite helpful if they would also prepare a brief paper outlining their views. Representatives from the American Health Information Management Association (AHIMA) and the American Hospital Association (AHA) indicated that they would make a request to present at the meeting. Other professional groups were urged to also consider making

such a request. This should be considered as only the beginning of the decision making process. However, it is an important first step.

There was general agreement within the audience that this approach to public discussion would assist in decision making. It was felt that a number of groups would be interested in making presentations.

CODING TOPICS

Intracardiac Echocardiography

Ann Fagan described the request for a specific ICD-9-CM code for intracardiac echocardiography. Lynn Purdy, Acuson, provided a technical description of the procedure. There was a general agreement for the need for a unique ICD-9-CM procedure code for the procedure. Although there was agreement on the proposed new title, there was some discussion about where the code should be placed. The HCFA recommendation was to assign it to proposed new code, 88.70, Intracardiac echocardiography, under category 88.7, Diagnostic ultrasound. One member of the audience suggested that the code be placed under category 37.2, Diagnostic procedures on heart and pericardium. Others agreed that category 37.2 might be preferable to category 88.7, and chose the other HCFA option of creating a new code at 37.28. There was no support for creating two codes to distinguish between with and without Doppler flow mapping. Instead, following the model that will be set forth by ICD-10-PCS, both the ICE and Doppler codes will be used to fully describe the procedure.

Transcervical Fetal Oxygen Saturation (FSpO₂) Monitoring

Amy Gruber described the request for a unique code for this procedure. Gary Dildy, MD, Professor of OB/GYN at the Louisiana State University Medical School, described the procedure. There was agreement on the need for a unique code for this procedure. There was some discussion on the proposed code title. Dr. Dildy mentioned that the proposed code title "Transcervical fetal oxygen saturation monitoring" may not always be appropriate since it can also be performed when the baby's head has emerged. Dr. Dildy also stated that the documentation for this procedure is usually "Fetal pulse oximetry." It was stated that this title might be shorter and more precise. Transcervical fetal oxygen saturation monitoring could then be used as an inclusion term. Written comments on the appropriate title were requested.

Removal of Intra-Aortic Balloon Pump

Ann Fagan described the coding of this procedure which has caused some confusion among coders. Four options were described. The audience agreed with the HCFA's recommendation of creating a new code under category 97.4, Nonoperative removal of therapeutic device from thorax, for the nonoperative removal of heart assist system. One participant also recommended that an excludes note be added under code 37.64, Removal of heart assist system, referring coders to 97.44. There was agreement with this suggestion.

Transabdominal Cerclage of Cervix

Amy Gruber described this request for a new procedure code for the abdominal approach to cerclage of the cervix. There was general agreement for the need to create a new code for this approach. One person expressed concern that documentation might not be clear to identify this

approach. Others thought this would not be a major problem. There was support for proposed new code 67.51, Transabdominal cerclage of cervix. One participant suggested a modification to the proposed code 67.59, Other cerclage of cervix. The participant recommended that this code be titled, "Other repair of internal cervical os", since the code would include other procedures in addition to other cerclages of cervix.

Lysis of adhesions

Ann Fagan led a discussion on the continuing problem of coding lysis of adhesions. She had addressed the topic previously at the May 11, 2000, ICD-9-CM Coordination and Maintenance meeting. Her proposed solution involved making a number of Index entries describing when lysis of adhesions should not be assigned a code. The audience felt this was an excellent solution. One physician member of the audience praised the clarity of the background paper on this issue as well as the solution. He concurred with the statement that lysis of adhesions should not be coded "unless adhesions are obstructive to an organ or impair or impede the normal function of an organ."

Proposed Addenda - FY 2002

Amy Gruber described the proposed addenda for FY 2002. For the most part, the audience agreed with the proposals. One participant suggested that HCFA reconsider establishing code 01.42, Operations on globus pallidus, as a default code for pallidotomy cases where the approach is not documented.

Conclusion of Procedure Portion of the Meeting

This concluded the procedure part of the meeting. Participants as well as those reading the summary were once again urged to carefully review the topics discussed and send their written comments to HCFA. Addresses are provided in the attachments. Those wishing to have a topic discussed at the May 17-18, 2001 meeting should send them in writing prior to March 17, 2001. Those wishing to make a presentation on whether the nation should replace ICD-9-CM procedure coding system with ICD-10-PCS should contact Pat Brooks by March 17, 2001. The agenda for the May 17, 2001 meeting will be posted on HCFA's web site in April 2001.

The meeting was then turned over to Donna Pickett, NCHS. A summary of NCHS's portion of the meeting can be found on their homepage as follows:

<http://www.cdc.gov/nchswww/about/otheract/icd9/maint/maint/htm>

Agenda
ICD-9-CM Coordination and Maintenance Committee
Department of Health and Human Services
Health Care Financing Administration
HCFA Auditorium
7500 Security Boulevard
Baltimore, MD 21244-1850
ICD-9-CM Volume 3, Procedures
November 17, 2000

Patricia E. Brooks
Co-Chairperson

9:00 AM ICD-9-CM Volume 3, Procedure presentations and public comments

Topics:

1. Implementation Issues on ICD-10 Procedure Classification System (PCS)
Patricia E. Brooks
2. Intracardiac Echocardiography
Ann B. Fagan
Ms. Lynn Purdy
Acuson
3. Transcervical Fetal Oxygen Saturation (FSpO₂) Monitoring
Amy L. Gruber
Gary Dildy, M.D.
Louisiana State University Hospital
4. Removal of Intra-Aortic Balloon Pump
Ann B. Fagan
5. Transabdominal Cerclage of Cervix
Amy L. Gruber

6. Lysis of Adhesions

Ann B. Fagan

7. Addenda

Amy L. Gruber

**ICD-9-CM Volume 3, Procedures
Coding Issues:**

Mailing Address:

**Health Care Financing Administration
CHPP, PPG, Division of Acute Care
Mail Stop C4-07-07
7500 Security Boulevard
Baltimore, MD 21244-1850**

FAX: (410) 786-0169

Patricia Brooks (410) 786-5318 email: pbrooks@hcfa.gov

Ann Fagan (410) 786-5662 email: afagan@hcfa.gov

Amy Gruber (410) 786-1542 email: agruber@hcfa.gov

Summary of Meeting:

A complete report of the meeting, including handouts, will be available on HCFA's homepage within one month of the meeting. Written summaries will no longer be mailed.

The summary can be accessed at:

<http://www.hcfa.gov/medicare/icd9cm.htm>

ICD-9-CM TIMELINE

A timeline of important dates in the ICD-9-CM process is described below:

- October 1, 1998 Complete, updated ICD-9-CM available on CD-ROM through the Government Printing Office at (202) 512-1800. Order number 017-022-01434-3. Cost \$18. This version of ICD-9-CM will be in effect from October 1, 1998 through September 30, 2000.
- May 13, 1999 ICD-9-CM Coordination and Maintenance Committee meeting. Code revisions discussed are for potential implementation on October 1, 2000.
- June 1999 Summary report of the Procedure part of the May 13, 1999 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA's homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>
- The Diagnosis part of the report will be posted on NCHS' homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- July 30, 1999 Hospital Inpatient Prospective Payment System final notice published in the Federal Register as mandated by Public Law 99-509. **Because of Y2K issues, no ICD-9-CM code revisions were allowed for October 1, 1999. No addendum was issued which would modify ICD-9-CM in any way. ICD-9-CM codes effective October 1, 1998 will remain in effect through September 30, 2000.**
- Sept. 10, 1999 Those members of the public requesting that topics be discussed at the November 12, 1999 meeting should have their requests to HCFA for procedures and NCHS for diagnoses.
- Oct. 1, 1999 Revisions to the Hospital Inpatient Prospective Payment System go into effect.
- Nov 12, 1999 ICD-9-CM Coordination and Maintenance Committee meeting. Last meeting of the year to discuss proposed code revisions for October 1, 2000.
- December 1999 Summary report of the Procedure part of the November 12, 1999 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA's homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>

The Diagnosis part of the report will be posted on NCHS= homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm

- January 7, 2000 Deadline for receipt of public comments on proposed code revisions. **Revisions will include all those discussed at FY 1999 (June 4, 1998 and November 2, 1998) and FY 2000 (May 13, 1999 and November 12, 1999) ICD-9-CM Coordination and Maintenance Committee meetings.**
- March 11, 2000 Those members of the public requesting that topics be discussed at the May 11-12, 2000 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to HCFA for procedures and NCHS for diagnoses.
- April 2000 Tentative agenda for the Procedure part of the May 11, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA=s homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>
- The Diagnosis part of the agenda will be posted on NCHS= homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- May 5, 2000 Notice of Proposed Rulemaking published in the Federal Register as mandated by Public Law 99-509. This included the final decisions on all ICD-9-CM code titles. It included proposed revisions to the DRG system, on which the public may comment.
- May 11, 2000 ICD-9-CM Coordination and Maintenance Committee meeting.
- June 2000 Summary report of the Procedure part of the May 11, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA=s homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>
- The Diagnosis part of the report will be posted on NCHS= homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- July 1, 2000 Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509.

- August 17, 2000 Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule published in Federal Register. Online version may be accessed through HCFA's homepage (www.hcfa.gov) through links for Administrative Simplification.
- Sept. 17, 2000 Those members of the public requesting that topics be discussed at the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to HCFA for procedures and NCHS for diagnoses.
- September 2000 Complete, updated ICD-9-CM available on CD-ROM through the Government Printing Office at (202) 512-1800. Order number 017-022-01499-8. Cost \$18. This version of ICD-9-CM will be in effect from October 1, 2000 through September 30, 2001.
- October 1, 2000 New and revised ICD-9-CM go into effect along with all other DRG changes.
- October 2000 Tentative agenda for the Procedure part of the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA's homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>
- The Diagnosis part of the report will be posted on NCHS homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- Nov. 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting in HCFA Auditorium.
- December 2000 Summary report of the Procedure part of the November 17, 2000 ICD-9-CM Coordination and Maintenance Committee meeting will be posted on HCFA's homepage as follows:
<http://www.hcfa.gov/medicare/icd9cm.htm>
- The Diagnosis part of the report will be posted on NCHS homepage as follows:
www.cdc.gov/nchswww/about/otheract/icd9/maint/maint.htm
- January 8, 2001 Deadline for receipt of public comments on proposed code revisions discussed at the May 11, 2000 and November 17,

2000 ICD-9-CM Coordination and Maintenance Committee meetings. These proposals are being considered for implementation on October 1, 2001.

- March 17, 2001 Those members of the public requesting that topics be discussed at the May 17-18, 2001 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to HCFA for procedures and NCHS for diagnoses.
- April 1, 2001 Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This will include the final decisions on all ICD-9-CM code titles. It will include proposed revisions to the DRG system, on which the public may comment.
- April 2001 Agenda for ICD-9-CM Coordination and Maintenance Committee Meeting posted on HCFA's homepage as follows: <http://www.hcfa.gov/medicare/icd9cm.htm>
- May 17-18, 2001 ICD-9-CM Coordination and Maintenance Committee Meeting in HCFA's auditorium. Code revisions discussed are for potential implementation on October 1, 2002.
- July 1, 2001 Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509.
- September 1, 2001 Those members of the public requesting that topics be discussed at the November 1-2, 2001 ICD-9-CM Coordination and Maintenance Committee meeting should have their requests to HCFA for procedures and NCHS for diagnoses.
- October 1, 2001 New and revised ICD-9-CM go into effect along with all other DRG changes.
- October 2001 Agenda for ICD-9-CM Coordination and Maintenance Committee Meeting posted on HCFA's homepage as follows: <http://www.hcfa.gov/medicare/icd9cm.htm>
- Nov.1-2, 2001 ICD-9-CM Coordination and Maintenance Committee Meeting. Code revisions discussed are for potential implementation on October 1, 2002.

ICD-10-PCS Update

11-1-00

Body Parts added to Root Operations

Body Part	Root Operation
Brain	Division
Kidney, Bilateral	Resection
Gallbladder	Bypass
Fascia	Division
Upper and Lower Gingiva	Change
Skull	Destruction, Division, Drainage, Excision, Insertion, Reattachment
Hair	Resection
Elbow	Detachment
Knee	Detachment
Esophagus	Repair
Sclera	Excision, Resection
Lens	Fragmentation
Stomach	Fragmentation
Intestines	Fragmentation
Lumbar Vertebral Disc	Resection
Scapula, Right	Reattachment, Revision

Body Parts Deleted from Root Operations

Body Part	Root Operation
Skull	Remove, Release
Anterior Chamber	Excision, Resection
Sacroiliac Joint	Resection
Sclera	Resection
Retina	Resection

Body Parts Deleted from Body System

Body Part	Body System
Ear	Subcutaneous Tissue

Approaches Added

Approach	Root Operation/ Body System
None	Drainage, Lower Arteries
Percutaneous	Bypass, Heart and Great Vessels

Approaches Deleted

Approach	Root Operation/Body System
None	Inspection, Cranial Cavity (Anatomical Region)
None	Excision, Mediastinum (Anatomical Region)

Index Entries

Index entries were updated to reflect all changes as noted above. Entries were also expanded to reflect more common usage terms; e.g. lumpectomy, laparotomy, mechanical ventilation, herniorrhaphy, etc.)

INTRACARDIAC ECHOCARDIOGRAPHY (ICE)

Issue:

There is no specific ICD-9-CM code describing intracardiac echocardiography (ICE). Is a unique code needed?

Background

Intracardiac echocardiography (ICE) was developed to assist invasive cardiologists in the catheterization and electrophysiology (EP) laboratories or in the critical care unit (CCU) or the intensive care unit (ICU) by providing direct, real-time 2-dimensional images and physiologic evaluation from inside the heart. ICE does not provide therapeutic benefits, but is a diagnostic tool used in the performance of another therapeutic procedure.

Through the ICE catheter, a physician is able to visualize therapeutic tools in relation to cardiac anatomy and physiology, optimizing the treatment. For use in ICE, single-use ultrasound transducers have been miniaturized to fit into small venous catheters measuring ~3.3 mm in diameter (10 French). An ICE catheter is inserted into the body's venous system using an introducer sheath, through either the femoral vein in the groin or from the internal jugular in the neck. As the physician advances the catheter tip toward the heart, he/she is continuously visualizing structures along the way. Once the catheter reaches the right atrium or ventricle, the imaging catheter is micro-positioned to see the targets of interest based on the procedure or therapy. Intracardiac ultrasound visualization and assessment of the heart during interventions may include such applications as:

- **Electrophysiology:** Visual assessment of target cardiac anatomy in therapeutic cases (e.g., ablation therapy for arrhythmias).
- **Interventional cardiology:** Blood flow measurements and anatomic assessment aid in the evaluation of cardiac function. Transseptal catheterizations of the intraatrial septum may be supported by the visualization of the septum and introducer sheath, guidewire and needle into the left side of the heart.
- **Minimally invasive cardiac surgery:** Placement of the therapeutic devices or tools in the heart can be seen using ICE (e.g., heart valves, septal closure devices, surgical tools).
- **CCU or ICU monitoring:** Ventricular function can be assessed over time through 2-D images and Doppler measurements from an ICE catheter resident in the heart during bedside monitoring.

Differences between ICE, Intravascular Ultrasound (IVUS), and conventional echocardiography ultrasound: Catheter-based ultrasound technology was introduced in the mid 1990's and was the precursor to conventional ICE. Intravascular ultrasound was developed for use in the cath lab for patients undergoing coronary artery interventions such as percutaneous transluminal catheter angioplasty (PTCA). During interventions, a therapeutic angioplasty balloon device is inserted into a coronary artery or peripheral vessel and inflated to open the obstruction caused by plaque or obstruction. IVUS provides a method to assess the outcome of the intervention by visualizing the inside of

the vessel and measuring the cross sectional area before and after the intervention. IVUS catheters are very small (2.9-3.2 French or 1.5 mm in diameter) and are used only

in the smallest of vessels, providing anatomical information from within a small coronary artery or peripheral vessel. IVUS is used only in target peripheral vessels and coronary arteries and not for imaging the entire heart.

Conventional echocardiography ultrasound has inherent acoustic barriers (e.g., lung and bone) that can reduce image quality. Conventional echocardiography requires physical positioning of patients in various maneuvers to optimize the image (e.g., left lateral decubitus position) which cannot be achieved in the operating room environment. Conventional ultrasound and IVUS do not permit real-time visualization of the therapeutic tools utilized in cardiac procedures.

Until atrial fibrillation (AF) ablation devices are available commercially in the US, the ICE devices are employed to provide visualization of therapeutic devices in the heart for routine procedures in the EP lab. In addition to ablation visualization, ICE can be used to visualize transeptal catheterization, minimally invasive valve surgery and percutaneous transmyocardial revascularization (PTMR) procedures today.

As minimally invasive therapy continues to advance in electrophysiology and interventional cardiology, the need for more sophisticated visualization of the heart will continue to expand. The industry is on the verge of many new minimally invasive therapies becoming commercially available in electrophysiology and interventional cardiology. For example, many catheter companies are working on special ablation catheters to treat patients with atrial fibrillation. In the United States there are over 2 million people with AF; there is no cure for AF today. Ablation therapy is likely to cure a number of AF cases and is the standard of care today in ablating less complicated arrhythmias including supraventricular tachycardia (SVT), reentrant tachycardia involving the AV node (AVNRT), atrial flutter, and Wolfe-Parkinson-White syndrome (WPW). As the Food and Drug Administration approves ablation therapy tools for AF, it is highly likely that many patients will be treated and cured of this abnormal heart rhythm using a combination of therapeutic catheters and ICE to visualize the procedure.

Coding Options

1. Create a unique code to describe this procedure:

	88	Other diagnostic radiology and related techniques
	88.7	Diagnostic ultrasound
New code	88.70	Intracardiac echocardiography
Add term		ICE
Add		Code also any synchronous Doppler flow mapping 88.72

2. Create two unique codes to describe this procedure, one with and one without Doppler flow mapping:

	37	Other operations on heart and pericardium
	37.2	Diagnostic procedures on heart and pericardium
New code	37.28	Intracardiac echocardiography without Doppler ICE
		Code also any synchronous Doppler flow mapping 88.72
	88	Diagnostic radiology and related techniques
	88.7	Diagnostic ultrasound
New code	88.70	Intracardiac echocardiography with Doppler ICE

3. Do not create a unique code for this procedure.

A code for cardiac ultrasound already exists at 88.72, Diagnostic ultrasound of heart (echocardiography) (intravascular ultrasound of heart), which is where this procedure is most correctly coded now. Code 88.72 also includes Dopplergram or Doppler flow mapping.

Recommendation

We recommend that option 1, the addition of one new code, be adopted as follows:

	88.7	Diagnostic ultrasound
New code Add term	88.70	Intracardiac echocardiography ICE
Add		Code also any synchronous Doppler flow mapping 88.72

Addition of one code will allow tracking of this technology with minimal disruption to the existing system. ICD-10-PCS will be coding each procedure uniquely, that is, separating them instead of lumping them together. Given that, it is our inclination to assign only one code with instruction to code also any Dopplergram performed.

In the Meantime:

Code intracardiac echocardiography (ICE) to 88.72, Diagnostic ultrasound of heart.

Transcervical Fetal Oxygen Saturation (FSpO₂) Monitoring

Issue:

Should a new code be created to uniquely capture transcervical fetal oxygen saturation monitoring? Currently, this monitoring is assigned to ICD-9-CM procedure code 75.34, Fetal monitoring, not otherwise specified.

Background:

Fetal oxygen monitoring technology provides clinicians with a direct measure of fetal oxygen status when an irregular fetal heart rate is present. As in adults, oxygen deficiency in an unborn child can lead to brain damage, neurological disorders or even death.

The intrapartum fetal oxygen monitor utilizes a single-use, disposable sensor that is inserted through the birth canal once the amniotic membranes have ruptured and the cervix is dilated past 2 centimeters. The sensor rests against the fetal cheek, forehead or temple and is held in place by uterine forces. As with traditional pulse oximetry, harmless red and infrared light shines into the baby's skin and the reflected light is captured and analyzed. The oxygen saturation is displayed on a monitor screen as a percentage. The normal oxygen saturation for a baby in the womb, receiving oxygenated blood from the placenta, is between 30 and 70 percent. The Food and Drug Administration has indicated that this monitor should only be used after maternal membranes have ruptured and on a singleton fetus in vertex presentation with a gestational age greater than or equal to 36 weeks.

Options:

1. Continue to code transcervical fetal oxygen saturation monitoring to code 75.34, Fetal monitoring, not otherwise specified.
2. Create a new code to capture transcervical fetal oxygen saturation monitoring under category 75.3, Other intrauterine operations on fetus and amnion.

New code 75.38 Transcervical fetal oxygen saturation monitoring
Fetal pulse oximetry
Transcervical fetal SpO₂ monitoring

With the creation of a new code, the code title for code 75.34, Fetal monitoring, not otherwise specified, would be modified to:

Code 75.34 Other fetal monitoring

Recommendation:

Option 2. Create a new code to capture transcervical fetal oxygen saturation monitoring under category 75.3, Other intrauterine operations on fetus and amnion.

New code 75.38 Transcervical fetal oxygen saturation monitoring
Fetal pulse oximetry
Transcervical fetal SpO2 monitoring

With the creation of a new code, the code title for code 75.34, Fetal monitoring, not otherwise specified, would be modified to:

Code 75.34 Other fetal monitoring

In the interim, continue to code transcervical fetal oxygen saturation monitoring to code 75.34, Fetal monitoring, not otherwise specified.

Transabdominal Cerclage of Cervix

Issue:

All cerclages of cervix are assigned to code ICD-9-CM procedure code 67.5, Repair of internal cervical os. Should code 67.5 be expanded to uniquely capture the abdominal approach?

Background:

Cerclage of the cervix is a surgical technique to reinforce the cervical muscle by placing sutures above the opening of the cervix to narrow the cervical canal. This procedure is used in the treatment of incompetent cervix.

Cervical incompetence, which is a cause of miscarriage and preterm birth in the second and third trimesters, is a condition in which the cervix begins to open (dilate) and thin (efface) before a pregnancy has reached term. In a woman with cervical incompetence, dilation and effacement of the cervix occur without pain or uterine contractions. Instead of happening in response to uterine contractions, as in normal pregnancy, these events occur because of the weakness in the cervix, which opens under the growing pressure of the uterus as pregnancy progresses. If the changes are not halted, rupture of the membranes and birth of a premature baby can result. According to statistics provided by the Mayo Clinic, cervical incompetence is relatively rare, occurring in only 1 to 2 percent of all pregnancies, but it is thought to cause as many as 20 to 25 percent of miscarriages in the second trimester.

Cerclage procedures usually entail closing the cervix through the vagina using a speculum. Another approach involves performing the cerclage through an abdominal incision. The transabdominal cerclage of cervix makes it possible to place the stitch exactly at the level that is needed. It can be carried out when the cervix is very short, effaced or totally distorted. The complications described in the literature have been rare: hemorrhage from damage to the veins at the time of the procedure; and fetal death due to uterine vessels occlusion.

Options:

1. Continue to code transabdominal cerclage of cervix to code 67.5, Repair of internal cervical os.

2. Expand code 67.5, Repair of internal cervical os, to the following:

New category	67.5 Repair of internal cervical os
New code	67.51 Transabdominal cerclage of cervix
New code	67.59 Other cerclage of cervix Cerclage of isthmus uteri McDonald operation Shirodkar operation Transvaginal cerclage

Recommendation:

Option 2. Expand code 67.5, Repair of internal cervical os, to the following:

New category	67.5 Repair of internal cervical os
New code	67.51 Transabdominal cerclage of cervix
New code	67.59 Other cerclage of cervix Cerclage of isthmus uteri McDonald operation Shirodkar operation Transvaginal cerclage

In the interim, continue to code transabdominal cerclage of cervix to code 67.5, Repair of internal cervical os.

LYSIS of ADHESIONS

Issue

There is confusion surrounding the definition and coding of lysis of adhesions, particularly digital or mechanical in a non-open procedure.

Background

This topic was brought before the May 11, 2000 C&M meeting, with the request that attendees and readers of the C&M web site consider the situation, and make any recommendations they felt were appropriate. No recommendations have been received.

Obviously, we want to avoid overstating the case unless adhesions are obstructive to an organ or impair or impede the normal function of an organ. We do not want to include or classify as adhesions the soft, flimsy, fibrinous bands that are easily taken down digitally and don't require the use of instrumentation. For example, the thorax may have adhesions that don't impede or restrict lung movement.

As a reminder from May's background paper, the coding guidelines printed in the American Hospital Association's publication, Coding Clinic for ICD-9-CM, fourth quarter 1990, pages 18 -19, gives the following information about adhesiolysis:

Coders should not code adhesions and lysis thereof, based solely on mention of adhesions or lysis in an operative report. Determination as to whether the adhesions and the lysis are significant enough to code and report must be made by the surgeon.

Adhesions from previous surgery are the most common cause of intestinal obstruction in the United States. When such obstruction is present, lysis of adhesions is usually the major procedure performed and both the diagnosis of adhesions and the procedure for lysis should be coded.

Occasionally, obstruction is not present, but a strong band of adhesions prevents the surgeon from access to the organ being removed, requiring lysis before the operation can proceed. In this case, both the diagnosis of adhesions and the lysis procedure should be coded.

Frequently, however, adhesions may exist without being organized and without causing any symptoms in the patient or increasing the difficulty of performing the operative procedure. When such minor adhesions exist and are easily lysed as part of the principal procedure, coding a diagnosis of adhesions and the procedure of lysis of adhesions is inappropriate. For example, some adhesions around the gallbladder are common and may be lysed as an integral part of the cholecystectomy. In this case, this is an incidental finding and coding of adhesions or their lysis would rarely be appropriate. Occasionally, the gallbladder is so encased in a strong band of adhesions that extensive lysis is required before the gallbladder is removed. In this case, coding of the adhesions and lysis would be appropriate.

Recommendation

We propose to add the following instructions to the Procedure Manual in the appropriate locations:

	Lysis	
		Adhesions
Add subterm		blunt – <i>omit code</i>
Add subterm		digital – <i>omit code</i>
Add subterm		manual – <i>omit code</i>
Add subterm		mechanical – <i>omit code</i>
Add subterm		without instrumentation – <i>omit code</i>

Proposed Addenda – FY 2002

Index

Add subterm	Application <u>adhesion barrier gel 99.29</u>
Revise subterm	Chemotherapy – <u>see also Immunotherapy</u>
Add subterm	Dialysis <u>liver 50.92</u>
Delete code	Echocardiography 88.72 transesophageal 88.72 [42.23]
Add subterm	Excision polyp – <u>see also Excision, lesion, by site</u> <u>rectum (endoscopic) 48.36</u>
Add subterm	Immunotherapy, antineoplastic 99.28 <u>Proleukin 99.28</u>
Add subterm	Injection (into) (hypodermically) (intramuscularly) (intravenously) (acting locally or systemically) <u>adhesion barrier gel 99.29</u>
Add subterm	<u>barrier gel, adhesion 99.29</u>
Add subterm	<u>gel, adhesion barrier 99.29</u>
Add subterm	Pallidotomy 01.42
Add subterm	<u>by stereotactic radiosurgery 92.32</u>
Add subterm	<u>cobalt 60 92.32</u>
Add subterm	<u>linear accelerator (LINAC) 92.31</u>
Add subterm	<u>multi-source 92.32</u>
Add subterm	particle beam 92.33
Add subterm	<u>particulate 92.33</u>
Add subterm	radiosurgery NEC 92.39
Add subterm	<u>single source photon 92.31</u>

Repair
stress incontinence (urinary) NEC 59.79
by
Add subterm tension free vaginal tape 59.79

Thalamotomy 01.41
Add subterm by stereotactic radiosurgery 92.32
Add subterm cobalt 60 92.32
Add subterm linear accelerator (LINAC) 92.31
Add subterm multi-source 92.32
Add subterm particle beam 92.33
Add subterm particulate 92.33
Add subterm radiosurgery NEC 92.39
Add subterm single source photon 92.31

Tabular List

01.41 Operations on thalamus
Chemothalamectomy
Thalamotomy
Add exclusion term Excludes: that by stereotactic radiosurgery (92.30 – 92.39)

01.42 Operations on globus pallidus
Pallidoansectomy
Pallidotomy
Add exclusion term Excludes: that by stereotactic radiosurgery (92.30 – 92.39)

50.92 Extracorporeal hepatic assistance
Add inclusion term Liver dialysis